

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155199	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Maple Park Village		STREET ADDRESS, CITY, STATE, ZIP CODE 776 N Union St Westfield, IN 46074	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>38872</p> <p>Based on observation, interview and record review, the facility failed to ensure a narcotic pain patch was administered at the correct time and new sites were used for the transdermal patch administration for 1 of 1 resident reviewed (Resident B) and failed to ensure staff were signing the narcotic count sheets for 4 of 6 medication cart narcotic logs reviewed.</p> <p>Findings include:</p> <p>1. During an interview, on 8/28/24 at 9:55 a.m., Resident B indicated she was experiencing pain and had been provided medication for the pain. The resident allowed observation of her Fentanyl pain patch. It was located on her right upper arm and dated 8/27/24. She indicated the patch was changed every three days. She was not aware of any missed doses of medications, including the narcotic pain patch.</p> <p>The clinical record for Resident B was reviewed on 8/28/24 at 11:29 a.m. The diagnoses included, but were not limited to, fibromyalgia, chronic pain, and polyneuropathy.</p> <p>A physician's order, initiated on 12/30/23 and discontinued on 7/22/24, indicated to administer one Fentanyl patch 50 mcg per hour every 72 hours. The special instructions indicated to rotate sites. The time of administration was 4:00 p.m., (the evening shift).</p> <p>The documentation on the MAR/TAR indicated, on 7/21/24, RN 1 checked off he had removed the old patch and placed a new patch to the resident's left shoulder at 2:12 p.m. The reason provided for the early administration of the medication indicated .Ls There was no other documentation to explain why the medication was administered early.</p> <p>The Controlled Substance Record indicated RN 1 signed out the narcotic patch on 7/21/24 at 3:00 p.m.</p> <p>The nursing schedule was reviewed on 8/29/24 at 2:27 p.m. RN 1 was scheduled and worked the day shift. His hours he worked were documented, on the schedule, as 6:27 a.m. to 3:14 p.m.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 8/28/24 at 2:27 p.m., the Executive Director indicated RN 1 was not able to say why he administered the Fentanyl patch early or if anyone witnessed the destruction of the old patch. RN 1 had pulled a patch which was due at 4:00 p.m., he could not recall if he placed the patch on the resident or if the patch had fallen off. He could not say why he pulled the medication early.</p> <p>During an interview, on 8/29/24 at 9:24 a.m., LPN 5 indicated staff were to check medication orders for the dose, resident, and time the medication was due to be administered. They also were to count the narcotics pre and post shift. The staff were to count all narcotic cards, bottles, patches, and medications. Two nurses were required to destroy medications and sign off on the form.</p> <p>2. During an interview, on 8/29/24 at 9:42 a.m., RN 6 indicated staff were to destroy medications with two nurses and sign off on the (destruction) sheet. The narcotic book should be signed at the beginning and end of every shift after the count. Old medication patches were to be removed and a new one put on with another nurse present, sites should be rotated, and staff should sign off the patch and destroy the old patch with another nurse.</p> <p>During the review of the MAR/TAR for Resident B it was noted a Fentanyl 50 mcg transdermal patch was administered to the resident's left shoulder on 7/18/24, a new patch was administered on 7/21/24 to the resident's left shoulder, and a new patch was administered on 7/25/24 to the resident's left shoulder.</p> <p>A physician's order, initiated on 12/30/23 and discontinued on 7/22/24, indicated to administer one Fentanyl patch 50 mcg per hour every 72 hours. The special instructions indicated to rotate sites.</p> <p>A physician's order, initiated on 7/25/24, indicated to administer one Fentanyl patch 50 mcg per hour every 72 hours. The special instructions indicated to remove the old patch first and rotate sites.</p> <p>3. During an interview, on 8/29/24 at 9:04 a.m., RN 4 indicated staff were to count all narcotic cards, bottles and patches. Staff needed to sign on/off in the narcotic logbook. Staff were to check for placement of medication patches every shift. Medication destruction needed to be completed with two nurses and both nurses must sign off on the destruction.</p> <p>The narcotic count sheets were reviewed for all units on 8/29/24 in conjunction with the medication pass administration.</p> <p>An untitled document used to count controlled substances, dated August 2024, for the Cottage (memory care) unit indicated the On-coming nurse signature and Off-going nurse signature was found to be missing signatures for the on-coming nurse for 3 of 85 entries and 7 of 85 entries for the off-going nurse.</p> <p>An untitled document used to count controlled substances, dated August 2024, for the Hall 2 North unit indicated the On-coming nurse signature and Off-going nurse signature was found to be missing signatures for the on-coming nurse for 1 of 85 entries and 2 of 85 entries for the off-going nurse.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An untitled document used to count controlled substances, dated August 2024, for the Moving Forward North unit indicated the On-coming nurse signature and Off-going nurse signature was found to be missing signatures for the on-coming nurse for 4 of 85 entries and 4 of 85 entries for the off-going nurse.</p> <p>An untitled document used to count controlled substances, dated August 2024, for the Moving Forward South unit indicated the On-coming nurse signature and Off-going nurse signature was found to be missing signatures for the on-coming nurse for 2 of 85 entries and 5 of 85 entries for the off-going nurse.</p> <p>A facility policy, titled General Dose Preparation and Medication Administration, dated as last revised 4/30/24 and received from the Executive Director on 8/29/24 at 1:20 p.m., indicated .Verify each time a medication is administered .at the correct time .Follow .medication administration guidelines .rotating transdermal patch sites</p> <p>A facility policy, titled Inventory of Controlled Substances, dated 2/1/18 and received from the Executive Director on 8/29/24 at 12:35 p.m., indicated .Facility will utilize the Shift change Verification of Controlled Substances form to count all controlled substance for each medication cart in the facility</p> <p>This Federal tag relates to Complaint IN00439443.</p> <p>3.1-25(b)</p> <p>3.1-25(e)(3)</p> <p>3.1-25(s)(8)</p>		